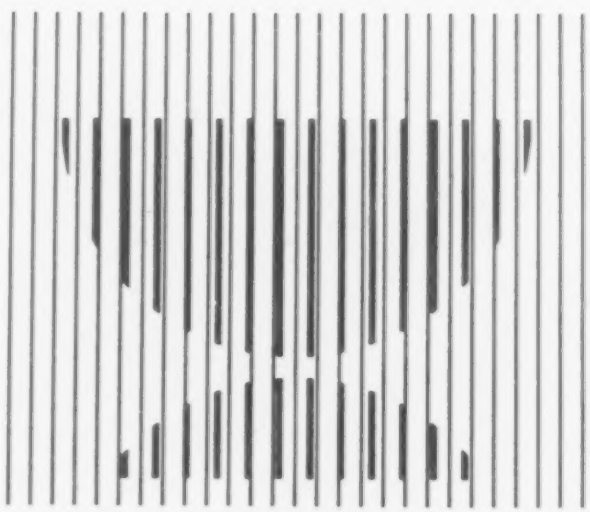
CBO STAFF MEMORANDUM

MEDICARE AND THE OMNIBUS BUDGET RECONCILIATION ACT OF 1990:

IMPACT ON ENROLLEES, HOSPITALS, AND PHYSICIANS

FEBRUARY 1991



THE CONGRESS OF THE UNITED STATES
CONGRESSIONAL BUDGET OFFICE
SECOND AND D STREETS, S.W.
WASHINGTON, D.C. 20515

J982-8

PREFACE

This memorandum examines the effects of the Medicare provisions contained in the Omnibus Budget Reconciliation Act of 1990 on federal spending, on enrollees' costs, and on Medicare's payments to hospitals and physicians. The first two sections were prepared by Sandra Christensen. The section on hospitals was written by Harriet L. Komisar, and the section on physicians by Scott Harrison. The extensive programming required for this analysis was done by Susan Hilton Labovich and Tahirih Senne Linton, and the final version of the manuscript was prepared by Jill Bury. This work was done in CBO's Human Resources and Community Development Division, under the direction of Nancy Gordon and Kathryn Langwell. Questions may be addressed to the authors: Sandra Christensen (202/226-2665), Harriet L. Komisar (202/226-2655), or Scott Harrison (202/226-2820).

CONTENTS

INTRODUCTION AND SUMMARY 1

IMPACT ON TOTAL COSTS AND ON NET FEDERAL COSTS 1

IMPACT ON ENROLLEES 3

- Provisions Affecting Enrollees' Costs 3
- Estimated Effects on Enrollees' Costs 6

IMPACT ON PPS HOSPITALS 6

- Provisions Affecting PPS Payments and Capital-Related Payments to PPS Hospitals 8
- Estimated Effects on PPS Hospitals 11

IMPACT ON PHYSICIANS 15

- Provisions Affecting Payments to Physicians 19
- Estimated Effects on Physicians 21

APPENDIX A 25

TABLES

Table 1.	Total Costs for Health Care Under Medicare (In calendar years, millions of dollars)	2
Table 2.	Net Federal Costs for Health Care Under Medicare (In calendar years, millions of dollars)	4
Table 3.	Enrollees' Copayment, Balance-Billing, and Premium Costs Under Medicare (In calendar years, dollars per enrollee)	7
Table 4.	The Change in PPS Payments Under OBRA-90 Relative to Previous Law (Fiscal years 1991, 1995, and the 1991-1995 period)	12
Table 5.	The Change in PPS Payments Plus Payments for Capital-Related Expenses Under OBRA-90 Relative to Previous Law (Fiscal years 1991, 1995, and the 1991-95 period)	16
Table 6.	The Change in Payment Rates and Effective Rates for Physicians' Services Under OBRA-90 Relative to Previous Law (In percent)	23
Table 7.	The Change in Medicare's Payments and Physicians' Receipts Under OBRA-90 Relative to Previous Law, After Incorporating Behavioral Responses (In percent)	24
Appendix Table 1.	Cost Estimates for Medicare Provisions Under OBRA-90 (In fiscal years, millions of dollars)	26

INTRODUCTION AND SUMMARY

This memorandum examines the Medicare provisions contained in the Omnibus Budget Reconciliation Act of 1990 (OBRA-90). It presents estimates of the entire act's impact on total costs for health care under Medicare, as well as its impact on net federal costs and on enrollees' costs. (Net federal costs are Medicare's reimbursements minus premium receipts. Enrollees' costs include Medicare's premiums and cost-sharing requirements.) The memorandum goes on to describe in detail, and to assess the impact of, the major payment provisions under the act that will affect hospitals and physicians. For hospitals, the analysis presents detailed information about how the impact will differ by type of hospital--by size, location, ownership, and other characteristics. For physicians, the analysis shows results by specialty and by whether the practice is urban or rural.

All of the estimates presented are for incurred costs--that is, for the costs of services provided during the period examined. Changes caused by the act are measured relative to what would have occurred had previous law been unchanged. Results are shown for federal fiscal years in the section on hospitals, but are for calendar years elsewhere. This difference is because changes in payment rates for hospitals are normally effective at the start of the federal fiscal year, beginning on October 1. By contrast, changes in payment rates for physicians, and changes in copayment requirements and premium amounts for enrollees, are normally effective at the start of the calendar year.

Under the provisions of OBRA-90, enrollees' premiums under the Supplementary Medical Insurance (SMI) program will increase, as will the SMI deductible amount. The deductible amount under the Hospital Insurance (HI) program, however, will be reduced relative to its value under previous law. Payments to hospitals will be reduced under the HI program, on balance, and payments to both physicians and to hospital outpatient departments will be reduced under the SMI program. Finally, collections from other insurers to compensate Medicare for some services used by Medicare enrollees will be increased.

As a result of these provisions, total health care costs under Medicare are expected to fall by 4.7 percent in total over the period from 1991 through 1995, compared to previous law. Net federal costs will be lower by 6.9 percent, a drop that will exceed the fall in total costs because a larger share of total costs will be transferred to enrollees. Enrollees' costs will be higher by 3.4 percent over the five-year period, due to higher SMI premiums only partially offset by lower cost-sharing.

IMPACT ON TOTAL COSTS AND ON NET FEDERAL COSTS

Under the provisions of OBRA-90, total health care costs under Medicare will be reduced by an estimated 3 percent for 1991, relative to projected costs under previous law (Table 1). Total costs for the HI program will be lower by 2 percent, while total costs for the SMI program will be lower by 4.3 percent.

TABLE 1. TOTAL COSTS FOR HEALTH CARE UNDER MEDICARE (In calendar years, millions of dollars)

Year	Total Costs			Net Federal Costs a/			Enrollees' Costs b/		
	HI	SMI	Total	HI	SMI	Total	HI	SMI	Total
Projections Prior to Passage of OBRA-90									
1990	70,950	56,055	127,005	64,833	30,765	95,598	6,117	25,289	31,406
1991	78,099	64,107	142,206	71,602	37,660	109,262	6,497	26,447	32,944
1992	86,440	72,053	158,494	79,308	43,493	122,801	7,752	28,560	35,692
1993	95,253	81,398	176,652	87,502	50,436	137,938	7,752	30,963	38,714
1994	104,728	91,757	196,486	96,289	58,042	154,331	8,439	33,716	41,155
1995	114,708	103,414	218,122	105,546	66,683	172,229	9,162	36,731	45,893
Projections After Passage of OBRA-90									
1990 c/	70,455	55,960	126,415	64,338	30,670	95,008	6,117	25,289	31,406
1991	76,505	61,373	137,878	70,009	34,904	104,912	6,497	26,469	32,966
1992	83,367	68,208	151,575	76,364	39,632	115,996	7,003	28,576	35,579
1993	90,582	76,905	167,487	83,095	44,669	127,764	7,487	32,236	39,724
1994	99,705	86,621	186,326	91,582	50,459	142,041	8,123	36,162	44,285
1995	109,299	97,708	207,007	100,461	57,103	157,564	8,838	40,605	49,443
Percentage Change in Projections									
1990 c/	-0.7	-0.2	-0.5	-0.8	-0.3	-0.6	0.0	0.0	0.0
1991	-2.0	-4.3	-3.0	-2.2	-7.3	-4.0	0.0	0.1	0.1
1992	-3.6	-5.3	-4.4	-3.7	-8.9	-5.5	-1.8	0.1	-0.3
1993	-4.9	-5.5	-5.2	-5.0	-11.4	-7.4	-3.4	4.1	2.6
1994	-4.8	-5.6	-5.2	-4.9	-13.1	-8.0	-3.7	7.3	5.1
1995	-4.7	-5.5	-5.1	-4.8	-14.4	-8.5	-3.5	10.5	7.7
1991-95	-4.1	-5.3	-4.7	-4.3	-11.5	-6.9	-2.6	4.9	3.4

SOURCE: Congressional Budget Office.

NOTE: The estimates in the table are incurred amounts for calendar years under CBO's summer 1990 baseline. OBRA-90 refers to the Omnibus Budget Reconciliation Act of 1990.

a. Federal reimbursements for HI and SMI services, minus SMI premium receipts.

b. Copayment, balance-billing, and premium costs under Medicare.

c. Under OBRA-90, the update to HI payment rates was delayed from October 1, 1990, until January 1, 1991. Payments to providers under the SMI program were reduced by 2 percent for services provided during November and December 1990.

For the five years from 1991 through 1995, changes due to OBRA-90 will be larger. Total health care costs under Medicare will be reduced by 4.7 percent overall, relative to projected costs under previous law. HI costs will be lower by 4.1 percent over the five-year period, and SMI costs will be lower by 5.3 percent.

Net federal costs under Medicare will be reduced by 4 percent--or $4.4 billion--in 1991, relative to previous law (Table 2). Over the period from 1991 through 1995, net federal costs will be lower by 6.9 percent, or $48.3 billion. Of these five-year savings, an estimated 57.5 percent will come from reduced payment rates for providers, with the effects about equally divided between the HI (29 percent) and the SMI (28.5 percent) programs. Another 28 percent will result from higher payment requirements imposed on enrollees. About two-thirds of the new enrollee costs will come from higher premiums, and the rest from benefit changes (a higher deductible partially offset by newly covered services). The remaining 14 percent of net federal savings will be the result of projected savings from extending and improving enforcement of requirements for collection from other insurers when Medicare is not the primary payer.

IMPACT ON ENROLLEES

This section examines the impact of OBRA-90 on enrollees' costs--that is, on the copayment (deductible and coinsurance), balance-billing, and premium costs for which enrollees are liable under Medicare. A part of these costs are covered by other payers (Medicaid, retiree health plans, or medigap insurers), but the effects of this supplementary coverage on who actually pays for enrollees' liabilities are not examined here.

Provisions Affecting Enrollees' Costs

Four provisions under the act will affect enrollees' costs under Medicare directly.

- Monthly SMI premiums will be higher as of 1992 (shown in Table 3). Under previous law, SMI premiums for 1991 and subsequent years would have increased from the 1990 value at the same rate as the cost-of-living adjustment (COLA) to Social Security benefits. Under OBRA-90, premium amounts are written into law for 1991 through 1995, and later increases will be determined by the COLA. The amounts written into law are CBO's estimates (at the time of enactment, in 1990) of the premiums necessary to cover 25 percent of the SMI insurance value for an aged enrollee. They may turn out to be either higher or lower than the premiums that would have been set by Medicare's actuaries under a continuation of the 25-percent rule.

- The SMI deductible amount was increased from $75 to $100 a year as of 1991.

TABLE 2. NET FEDERAL COSTS FOR HEALTH CARE UNDER MEDICARE (In calendar years, millions of dollars)

	1990	1991	1992	1993	1994	1995	Total 1991-95
Projections of Incurred Costs Prior to Passage of OBRA-90							
HI Spending	64,833	71,602	79,308	87,502	96,289	105,546	440,248
SMI Spending	41,890	49,441	55,939	63,599	71,943	81,340	322,262
Premiums a/	-11,124	-11,781	-12,446	-13,164	-13,902	-14,657	-65,949
Net Federal Spending	95,598	109,262	122,801	137,938	154,331	172,229	696,561
Change in Incurred Costs Under OBRA-90							
HI Spending							
Provider payments	-495	-1,554	-2,102	-3,405	-3,351	-3,610	-14,023
Primary payer collections a/		-39	-842	-1,002	-1,356	-1,475	-4,715
Total	-495	-1,594	-2,945	-4,407	-4,707	-5,085	-18,738
SMI Spending							
Provider payments	-95	-2,358	-2,680	-2,847	-2,907	-2,963	-13,754
Enrollee benefits		-332	-568	-851	-1,178	-1,537	-4,465
Primary payer collections a/		-67	-374	-454	-595	-649	-2,139
Total	-95	-2,756	-3,621	-4,152	-4,679	-5,150	-20,359
Premiums a/	0	0	-239	-1,615	-2,903	-4,430	-9,188
Net Change	-590	-4,350	-6,806	-10,174	-12,290	-14,665	-48,285
Percentage Change	-0.6	-4.0	-5.5	-7.4	-8.0	-8.5	-6.9
Projections of Incurred Costs After Passage of OBRA-90							
HI Spending	64,338	70,009	76,364	83,095	91,582	100,461	421,509
SMI Spending	41,795	46,685	52,317	59,448	67,264	76,190	301,904
Premiums a/	-11,124	-11,781	-12,685	-14,779	-16,805	-19,087	-75,137
Net Federal Spending	95,008	104,912	115,996	127,764	142,041	157,564	648,276

SOURCE: Congressional Budget Office.

NOTES: The estimates in the table are incurred amounts for calendar years under CBO's summer 1990 baseline. OBRA-90 refers to the Omnibus Budget Reconciliation Act of 1990.

These estimates differ from CBO's cost estimate for OBRA-90 for three reasons: results are for calendar years, not fiscal years; incurred costs are shown, not outlays; and estimates of offsetting Medicaid costs are not included. See Appendix Table 1 for CBO's cost estimate.

a. Premium receipts and increases in collections from primary insurers are presented as negative costs, or savings.

- Coverage was extended to include biennial screening mammography for women as of 1991.

- Coverage was extended to include injectable calcitonin (a drug to prevent osteoporosis) for enrollees also receiving home health benefits as of 1991.

In addition, many of the provisions affecting payment rates for providers will have an indirect effect on enrollees' costs, typically reducing them. For example, because the HI deductible amount is indexed to the update factor for hospital payment rates, the act's reduction in this update factor will reduce the HI deductible amount for 1992 and subsequent years. This, in turn, will reduce enrollees' copayment costs for inpatient and skilled nursing facility (SNF) services.[1]

Similarly, the reduction in payment rates for physicians' services will reduce enrollees' coinsurance costs on those services relative to what they would have been. The reduction in rates for physicians' services may cause enrollees' balance-billing costs either to fall or to rise, depending on whether their physicians' actual charges are at or below the limits set in law. (For most services, physicians' actual charge in 1991 may not exceed 125 percent of the prevailing charge for that service.) On average, enrollees' balance-billing costs will fall under the provisions of OBRA-90.

OBRA-90 also contains provisions affecting enrollees' supplementary coverage from Medicaid and medigap policies, whose effects are not shown in the estimates of the impact on enrollees' costs discussed in the next section.

- The date by which all poor enrollees will be eligible for Medicaid coverage of copayment and premium costs under Medicare was advanced from January 1992 to January 1991. Under previous law, eligibility was mandatory in 1991 only for Medicare enrollees with income less than 95 percent of the poverty line.[2]

- The standards that insurance policies must meet to be legally marketed as medigap policies or Medicare supplements are to be revised by 1992. All insurers are to offer the same basic policy, although up to nine alternative benefit packages (each of which is to incorporate the basic package) may be offered as well. The National Association of Insurance Commissioners is to develop a uniform description of each of the 10 allowable benefit packages. Insurers

---

1. The HI deductible amount and HI copayment costs for 1991 would have been reduced by nearly 2 percent if OBRA-90 had been passed earlier. By the time of passage, however, the 1991 HI deductible amount of $628 had already been promulgated, and the Administration has implemented the promulgated amount.

2. As of 1993, Medicaid will also be required to pay Medicare premiums--but not copayment costs--for enrollees with income less than 110 percent of poverty. As of 1995, this requirement will include all enrollees with income less than 120 percent of poverty.

are prohibited from selling medigap policies to enrollees who have another policy in force, or to those receiving Medicaid benefits. Medigap insurers must permit part-year enrollment for those with only part-year coverage under Medicaid.

Estimated Effects on Enrollees' Costs

For 1991, enrollees' costs will be higher by 0.1 percent or about $1 a year, virtually unchanged by the provisions of OBRA-90 (Table 3). Reductions in payment rates for SMI providers will reduce enrollees' coinsurance and balance-billing costs relative to previous law, but the higher SMI deductible will almost exactly offset these savings. Enrollees' premium costs will be unchanged for 1991, relative to the premium that would otherwise have been in effect.

SMI copayment (deductible and coinsurance) costs will increase by 0.2 percent for 1991, but balance-billing costs will fall by 0.3 percent. Balance-billing costs will be higher on evaluation and management services, for which the 1991 limiting charge on unassigned claims was increased from 125 percent to 140 percent of the prevailing charge. On average over all services, however, balance-billing costs will be lower because the limiting charges tend to force actual charges down when Medicare's payment rates are reduced.

Additional reductions in payment rates for providers are specified for years after 1991 under the act, and the cumulative effect of these reductions will also reduce enrollees' copayment and balance-billing costs relative to previous law. Enrollees' copayment costs under the HI program will be lower by 2.6 percent in total over the period from 1991 through 1995. Copayment costs under the SMI program will be lower by about 1.5 percent, and balance-billing costs will be lower by 4.1 percent Copayment and balance-billing costs combined will be 2 percent lower than they would otherwise have been.

The SMI premiums specified in the act for 1992 through 1995 will be higher than they would have been under previous law. Over the five-year period from 1991 through 1995, premium costs will be 13.7 percent higher. The financial effect of the premium increases will be the larger one, so that enrollees' costs per capita under Medicare will be higher by 3.3 percent because of the act. By 1995, enrollees' costs per capita will be an estimated $97 higher than they would have been under previous law.

IMPACT ON PPS HOSPITALS

This section examines the impact of the major provisions under OBRA-90 that will affect amounts paid to hospitals that are reimbursed under the Prospective Payment System (PPS). It includes changes in PPS payments (payments for the operating expenses associated with treating Medicare patients) and in payments to hospitals for capital-related expenses, which account for nearly all of the changes affecting

TABLE 3. ENROLLEES' COPAYMENT, BALANCE-BILLING, AND PREMIUM COSTS UNDER MEDICARE (In calendar years, dollars per enrollee)

Year	HI Copays	SMI Copays	SMI Balance Billing	Total Copays & Balance Billing	Monthly SMI Premiums	Annual SMI Premiums	Total Enrollees' Costs
Projections Prior to Passage of OBRA-90							
1990	180	344	73	598	28.60	328	926
1991	188	382	43	613	29.90	341	954
1992	203	417	42	662	31.20	355	1,017
1993	218	459	41	717	32.60	369	1,087
1994	233	503	45	782	34.00	385	1,166
1995	250	553	50	852	35.40	400	1,252
Projections After Passage of OBRA-90							
1990	180	344	73	598	28.60	328	926
1991	188	383	43	613	29.90	341	955
1992	200	413	40	652	31.80	362	1,014
1993	210	451	39	700	36.60	415	1,115
1994	225	493	43	760	41.10	465	1,225
1995	241	540	47	828	46.10	521	1,349
Percentage Change in Projections							
1990	0.0	0.0	0.0	0.0	0.0	0.0	0.0
1991	0.0	0.2	-0.3	0.1	0.0	0.0	0.1
1992	-1.8	-1.1	-4.3	-1.5	1.9	1.9	-0.3
1993	-3.4	-1.6	-5.2	-2.4	12.3	12.3	2.6
1994	-3.7	-2.0	-5.3	-2.7	20.9	20.9	5.1
1995	-3.5	-2.3	-5.2	-2.8	30.2	30.2	7.7
1991-95	-2.6	-1.5	-4.1	-2.0	13.7	13.7	3.3

SOURCE: Congressional Budget Office.

NOTES: The estimates in the table are incurred amounts for calendar years under CBO's summer 1990 baseline. OBRA-90 refers to the Omnibus Budget Reconciliation Act of 1990.

The annual SMI premium amounts are less than the monthly amounts times 12 because not all those counted as Medicare enrollees are enrolled in the SMI program for the full year.

PPS hospitals. Changes in direct payments for graduate medical education, however, are not included in the analysis. Provisions affecting other HI providers (including PPS-exempt hospitals) are not examined here.

Provisions Affecting PPS Payments and Capital-Related Payments to PPS Hospitals

OBRA-90 makes a series of changes in PPS payments and payments for capital-related expenses that will become effective over the five fiscal years from 1991 through 1995. The PPS payment policies described below for fiscal year 1991 are effective from January 1, 1991, through the remainder of the federal fiscal year. From October 21 through December 31, 1990, PPS payment rates were fixed at fiscal year 1990 amounts. Separate rules applied to PPS payments for the first part of October.[3] The 1991 changes in capital-related payments are effective for the entire fiscal year.

Change in the Update Factors and Reduction in the Urban/Rural Differential in Standardized Amounts. Two provisions affect the annual update factors for PPS rates. First, the basic annual update for all hospitals will be less than the marketbasket increase (which was the "previous law" update) for fiscal years 1991 through 1993, and will equal the marketbasket increase for 1994 and 1995. Second, additional increases will be applied to the rural update each year, so that by 1995 the rural and "other urban" standardized amounts will be equal.[4] The net result of these two changes is that the rural update will be greater than the urban update (which applies to hospitals in all urban areas and to rural referral hospitals) each year. For 1991 through 1993, both the rural and urban updates will be below the marketbasket increases. For 1994 and 1995, the urban update will equal the marketbasket increase, while the rural update will be greater than the marketbasket increase.

The urban and rural updates for fiscal years 1991 through 1995 are given below (in percentage points, where M indicates the marketbasket increase):[5]

---

3. In particular, from October 1 through October 20, the final regulations for PPS payments (published September 4, 1990) were in effect with two exceptions: the fiscal year 1990 wage index (which is based on 1984 data) continued to apply instead of a new wage index (based on 1988 data), and the regional floor policy was continued in a budget-neutral fashion instead of expiring at the end of fiscal year 1990.

4. Currently, separate standardized amounts apply to hospitals in rural areas, large urban areas (those with more than 1 million people), and "other urban" areas (those with 1 million or fewer people). Rural referral centers, however, are paid according to the "other urban" standardized amount.

5. The estimated marketbasket increases in CBO's summer 1990 baseline for 1991 through 1995 were 5.2 percent, 5.7 percent, 5.6 percent, 5.6 percent, and 5.6 percent, respectively.

	Urban	Rural
1991	M - 2.0	M - 0.7
1992	M - 1.6	M - 0.6
1993	M - 1.55	M - 0.55
1994	M	M + 1.5
1995	M	M + whatever is needed to equalize the rural and "other urban" standardized amounts.

The estimated five-year cumulative update will be 25 percent for hospitals qualifying for urban rates (that is, urban and rural referral hospitals), and 34 percent for hospitals receiving the rural rate, compared with an estimated cumulative marketbasket increase of 31 percent.

Under OBRA-90, the standardized amounts will also be affected in 1995 by a change in the method used to adjust them for outlier payments. Currently, separate reduction factors are applied to urban and rural standardized amounts based on the proportion of estimated payments attributable to outlier payments for hospitals located in urban and rural areas. In 1995, a single outlier reduction will be applied instead. This change will reduce aggregate payments to rural hospitals by about 2 percent, and increase aggregate payments to urban hospitals by about one-half percent, compared to applying separate outlier reductions, since rural hospitals generally have a lower proportion of payments attributable to outlier payments than urban hospitals have.[6]

Increase in Disproportionate Share Payments. Under OBRA-90, the disproportionate share adjustment (which provides additional payments to hospitals that serve a disproportionately high share of low-income patients) will increase progressively over the five-year period for urban hospitals that have 100 or more beds.[7] For urban hospitals that have 100 or more beds and a "disproportionate patient percentage" of more than 20.2 percent, increases in the disproportionate share adjustment will occur in fiscal years 1991, 1994, and 1995.[8] For this group of hospitals, the disproportionate share adjustments under previous law and OBRA-90

---

6. For example, the current standardized amounts for urban and rural areas were reduced by 5.6 percent and 2.3 percent, respectively, to offset estimated outlier payments for hospitals located in each area.

7. OBRA-90 will also increase the disproportionate share adjustment for the few hospitals (less than 10 in 1988) that qualify for the adjustment based on having a relatively high share of revenue attributed to indigent care payments from state and local governments. Beginning January 1, 1991, the disproportionate share adjustment for these hospitals will be 35 percent, instead of 30 percent.

8. A hospital's "disproportionate patient percentage" is defined as the percent of the hospital's Medicare patient days attributable to Supplemental Security Income Medicare beneficiaries plus the percent of total patient days that are attributable to Medicaid patients.

are computed according to the following formulas (in percentage points, where P is the hospital's disproportionate patient percentage):

	Previous Law Adjustment	OBRA-90 Adjustment
1991-1993	(P-20.2).65 + 5.62	(P-20.2).7 + 5.62
1994	(P-20.2).65 + 5.62	(P-20.2).8 + 5.88
1995	(P-20.2).65 + 5.62	(P-20.2).825 + 5.88

For urban hospitals with 100 or more beds and a disproportionate patient percentage of more than 15 percent but not more than 20.2 percent, the adjustment will rise in 1994:

	Previous Law Adjustment	OBRA-90 Adjustment
1991-1993	(P-15).6 + 2.5	(P-15).6 + 2.5
1994-1995	(P-15).6 + 2.5	(P-15).65 + 2.5

When the changes are fully implemented in 1995, disproportionate share payments will be about 17 percent higher for the first group and about 3 percent higher for the second group, or about 15 percent higher on average for both groups.

Extension of the "Regional Floor". A "regional floor" has been in effect for PPS payments since April 1, 1988. Under this policy, the standardized amount for each hospital is determined by the higher of two amounts: the national amount, or the sum of 85 percent of the national amount plus 15 percent of the regional amount. Under previous law, the regional floor was due to expire at the end of fiscal year 1990 so that, beginning with fiscal year 1991, the standardized amount would have been equal to the national amount. Instead, OBRA-90 will continue the regional floor through fiscal year 1993.

Reduced Payments for Capital-Related Expenses. In fiscal year 1991, payments for capital-related expenses will be reduced by 15 percent for all hospitals covered by the PPS except sole community hospitals and rural primary care hospitals. Beginning in 1992, payments for capital-related expenses will be determined on a prospective basis, in contrast to the current retrospective, cost-based method. Under the new prospective system, aggregate payments for capital-related expenses are to be 10 percent less than they would have been under previous law (sole community and rural primary care hospitals excluded) for 1992 through 1995.

Estimated Effects on PPS Hospitals

This section compares payments under OBRA-90 with payments under previous law for three time periods: fiscal year 1991, the first year to which OBRA-90 applies; fiscal year 1995, when OBRA-90 will be fully implemented; and the 1991-1995 period. First, only changes in PPS payments (that is, payments for operating expenses) are examined. Then, the combined effects of changes in PPS payments plus capital-related payments to PPS hospitals are shown. The analysis does not include any potential effects that the transition to prospectively determined payments for capital-related expenses might have on the distribution of payments among hospitals.

Effects on PPS Payments. In fiscal year 1991, the first year affected by OBRA-90, total PPS payments will be approximately 2.0 percent less than they would have been under previous law (see Table 4).[9] Although payments will be reduced in all hospitals, the size of the reductions will vary among hospitals according to urban-rural status, region, and certain hospital characteristics. In particular, the average reduction in payments will be larger for urban hospitals than for rural hospitals, because of the higher rural update. Payments to urban hospitals will fall by 2.1 percent compared with a 1.5 percent decrease for rural hospitals. The change for rural hospitals reflects the combined effects of a 2.1 percent reduction for rural referral hospitals (which qualify for the "other urban" standardized amount and therefore the urban update) and a 1.2 percent decrease for rural hospitals that are not rural referral hospitals. Disproportionate share hospitals in urban areas will have a slightly smaller reduction in payments than other urban hospitals. For example, payments to disproportionate share hospitals in large urban areas will decrease by 2.1 percent, compared with a reduction of 2.2 percent for nondisproportionate share hospitals in large urban areas.

The change in payments for fiscal year 1991 will also vary across census divisions. The New England, Middle Atlantic, and South Atlantic regions will have the greatest payment changes (-2.5 percent, -2.5 percent, and -2.6 percent, respectively), while the East North Central, West North Central, and West South Central regions will have the smallest changes (-1.0 percent, -1.4 percent, and -1.7 percent, respectively). This pattern results primarily from regional differences in three factors: the relative proportions of payments to urban and rural hospitals, the average effects of the slower transition under OBRA-90 to a 1988-based wage index, and the impact of the continuation of the regional floor.[10]

---

9. The estimates for 1991 take account of the freeze on payment rates and other policies affecting the first quarter of the fiscal year, as well as policies that became effective on January 1, 1991.

10. The implementation of a 1988-based wage index (instead of a 1984-based one) was delayed until January 1, 1991, instead of becoming effective at the beginning of fiscal year 1991. Payments to the areas that will benefit the most from a 1988-based wage index are negatively affected by the slower transition, while payments to areas that will benefit least from the 1988-based wage index are positively affected. Payments to hospitals benefiting from the regional floor policy are also positively affected by OBRA-90.

TABLE 4. THE CHANGE IN PPS PAYMENTS UNDER OBRA-90 RELATIVE TO PREVIOUS LAW (Fiscal years 1991, 1995, and the 1991-1995 period)

Category	Number of Hospitals	PPS Payments Under Previous Law (1991, in millions of dollars) a/	Change in PPS Payments Under OBRA-90 (In percent)		
			1991	1995	1991-95
Total	5,737	52,820	-2.0	-3.7	-3.4
Urban	3,109	45,290	-2.1	-4.0	-3.7
Rural	2,628	7,540	-1.5	-2.1	-2.0
Urban					
MSA > 1 million b/	1,548	25,300	-2.1	-3.8	-3.6
Other urban	1,561	19,990	-2.1	-4.1	-3.7
Rural					
Rural referral	218	2,530	-2.1	-4.4	-3.9
Not rural referral	2,410	5,010	-1.2	-0.9	-1.0
Rural					
Rural referral	218	2,530	-2.1	-4.4	-3.9
Sole community c/	439	920	-1.4	-0.9	-1.0
Medicare dependent d/	485	720	-1.3	-0.9	-1.0
Other rural	1,486	3,360	-1.1	-0.9	-0.9
Disproportionate Share	1,577	21,830	-2.0	-3.3	-3.3
Nondisproportionate Share	4,160	30,990	-2.0	-4.0	-3.5
Disproportionate Share					
MSA > 1 million	574	11,000	-2.1	-3.0	-3.2
Other urban	620	9,660	-2.0	-3.7	-3.5
Rural	383	1,170	-1.8	-2.1	-2.1
Nondisproportionate Share					
MSA > 1 million	974	14,310	-2.2	-4.5	-3.9
Other urban	941	10,320	-2.1	-4.5	-3.9
Rural	2,245	6,360	-1.5	-2.1	-2.0
Teaching	1,191	27,540	-2.0	-3.8	-3.6
Nonteaching	4,546	25,280	-2.0	-3.5	-3.3
Major Teaching e/	228	8,000	-2.1	-3.3	-3.3
Other Teaching	963	19,540	-2.0	-4.0	-3.7
Major Teaching					
Disproportionate share	176	5,930	-2.0	-2.9	-3.1
Nondisproportionate share	52	2,070	-2.4	-4.5	-3.9

(Continued)

TABLE 4. (Continued)

Category	Number of Hospitals	PPS Payments Under Previous Law (1991, in millions of dollars) a/	Change in PPS Payments Under OBRA-90 (In percent) 1991	1995	1991-95
Other Teaching					
Disproportionate share	421	8,650	-2.0	-3.6	-3.5
Nondisproportionate share	542	10,900	-2.0	-4.4	-3.9
Urban					
≤ 100 beds	846	2,330	-2.2	-4.4	-4.0
101-200 beds	870	7,230	-2.2	-3.9	-3.7
201-400 beds	1,002	19,660	-2.1	-4.0	-3.7
401+ beds	391	16,070	-2.1	-3.9	-3.6
Rural					
≤ 50 beds	1,390	1,370	-1.2	-0.9	-1.0
51-100 beds	744	2,100	-1.2	-1.0	-1.0
101-200 beds	379	2,450	-1.6	-2.5	-2.3
201+ beds	115	1,620	-2.0	-3.8	-3.5
New England	244	3,280	-2.5	-4.5	-3.6
Middle Atlantic	637	10,510	-2.5	-4.1	-3.7
South Atlantic	781	8,030	-2.6	-3.9	-3.6
East North Central	868	9,150	-1.0	-4.2	-3.1
East South Central	493	3,420	-2.0	-3.5	-3.2
West North Central	799	3,770	-1.4	-3.8	-3.3
West South Central	824	4,930	-1.7	-3.7	-3.3
Mountain	398	2,200	-2.1	-3.9	-3.5
Pacific	693	7,530	-2.2	-4.0	-3.6
Voluntary	3,235	39,160	-2.0	-4.2	-3.5
Proprietary	1,161	6,370	-2.2	-3.8	-3.4
Urban Government	447	5,330	-2.0	-3.6	-3.2
Rural Government	894	1,960	-1.5	-1.5	-1.8

SOURCE: Congressional Budget Office estimates based on data provided by the Health Care Financing Administration and other sources.

NOTES: The estimates in the table are incurred amounts for fiscal years under CBO's summer 1990 baseline. OBRA-90 refers to the Omnibus Budget Reconciliation Act of 1990. Previous law means the law in effect on September 30, 1990.

Details may not sum to totals because of rounding.

a. Prospective payment system (PPS) payments are the payments received by hospitals covered by the PPS for the operating costs associated with providing inpatient services to Medicare beneficiaries, which include enrollees' copayments. They are based on prospectively set rates for each diagnosis-related group and include adjustments such as those for "disproportionate share" and indirect teaching costs. They do not include payments for capital-related expenses, the direct costs of graduate medical education, or other "pass-throughs."

TABLE 4. (Continued)

b. MSA > 1 million indicates hospitals located in Metropolitan Statistical Areas with populations of more than 1 million.

c. Sole community hospitals that are also rural referral hospitals are included in the rural referral category.

d. A Medicare dependent hospital is a rural hospital with 100 or fewer beds that is not a sole community hospital, and in which at least 60 percent of inpatient discharges or days during the hospital's 1987 fiscal year were attributable to Medicare beneficiaries. Medicare dependent hospitals qualify for payments similar to those for sole community hospitals (through March 1993).

e. Major teaching hospitals are those hospitals for which the ratio of the number of full-time equivalent interns and residents to the number of beds is .25 or larger.

In fiscal year 1995, when the provisions of OBRA-90 will be fully in place, total PPS payments will be 3.7 percent less than they would have been under previous law. The differences in the estimated effects of OBRA-90 across hospital categories are generally much larger in 1995 than in 1991, because 1995 payments reflect the full impact of the increases in rural and disproportionate share payments. Regional differences are an exception--these are less pronounced in 1995 than in 1991.

In fiscal year 1995, PPS payments to urban hospitals will be 4.0 percent less than they would have been under previous law, while payments to rural hospitals will be about 2.1 percent less than they would have been. Among rural hospitals, payments to rural referral hospitals will be 4.4 percent less than they would have been under previous law, while payments to those that are not rural referral hospitals will be 0.9 percent less. The effects of the fully phased-in disproportionate share policy can also be seen in the 1995 estimates. Payments to disproportionate share hospitals in large urban areas will decrease by 3.0 percent, compared to a fall of 4.5 percent for nondisproportionate share hospitals in large urban areas. Similarly, disproportionate share hospitals in other urban areas will face a smaller reduction (3.7 percent) than nondisproportionate share hospitals in those areas (4.5 percent).

For fiscal years 1991-1995, payments will be about 3.4 percent less than they would have been under previous law. Since the five-year effects on payments reflect the average of the effects on payments in each year, the differential effects on rural and urban hospitals and on urban disproportionate and nondisproportionate share hospitals will be larger for the five-year period than under 1991 policy but not as large as under 1995 policy. Payments will be 3.7 percent less than under previous law for urban hospitals, for example, and 2.0 percent less for rural hospitals (3.9 percent less for rural referral hospitals and 1.0 percent less for other rural hospitals).

Effects on PPS Payments Plus Capital-Related Payments. For most hospital groups, the sum of PPS and capital-related payments will decrease more, relative to previous law, in each fiscal year than PPS payments alone will (see Table 5). This result occurs because the reductions in capital-related payments will be greater (in percentage terms) than the changes in PPS payments. Sole community hospitals are an exception, since they are exempted from the reductions in capital-related payments.

IMPACT ON PHYSICIANS

This section examines the impact of the major provisions of OBRA-90 that will affect the rates and the amounts paid to physicians and related providers (limited license practitioners) for services covered by Medicare. Provisions that will extend coverage to new services or that will affect other SMI providers--hospital outpatient departments, suppliers of medical equipment, and nurse anesthetists--are not examined here.

TABLE 5. THE CHANGE IN PPS PAYMENTS PLUS PAYMENTS FOR CAPITAL-RELATED EXPENSES UNDER OBRA-90 RELATIVE TO PREVIOUS LAW (Fiscal years 1991, 1995, and the 1991-1995 period)

Hospital Category	Number of Hospitals	PPS and Capital Payments Under Previous Law (1991, in millions of dollars) a/	Change in PPS and Capital Payments Under OBRA-90 (In percent)		
			1991	1995	1991-95
Total	5,737	59,770	-3.5	-4.4	-4.3
Urban	3,109	51,210	-3.6	-4.6	-4.5
Rural	2,628	8,570	-2.9	-2.8	-2.8
Urban					
MSA > 1 million b/	1,548	28,550	-3.6	-4.5	-4.4
Other urban	1,561	22,650	-3.6	-4.8	-4.6
Rural					
Rural referral	218	2,860	-3.4	-4.9	-4.6
Not rural referral	2,410	5,010	-2.6	-1.8	-2.0
Rural					
Rural referral	218	2,860	-3.4	-4.9	-4.6
Sole community c/	439	1,040	-1.2	-0.8	-0.9
Medicare dependent d/	485	810	-2.7	-1.9	-2.1
Other rural	1,486	3,860	-2.9	-2.0	-2.2
Disproportionate Share	1,577	24,550	-3.4	-4.0	-4.1
Nondisproportionate Share	4,160	35,230	-3.5	-4.7	-4.4
Disproportionate Share					
MSA > 1 million	574	12,310	-3.4	-3.8	-4.0
Other urban	620	10,920	-3.5	-4.4	-4.4
Rural	383	1,320	-3.0	-2.8	-2.9
Nondisproportionate Share					
MSA > 1 million	974	16,250	-3.7	-5.1	-4.8
Other urban	941	11,740	-3.6	-5.1	-4.7
Rural	2,245	7,240	-2.8	-2.8	-2.8
Teaching	1,191	30,780	-3.4	-4.5	-4.3
Nonteaching	4,546	29,000	-3.6	-4.3	-4.2
Major Teaching e/	228	8,790	-3.3	-3.9	-4.0
Other Teaching	963	21,990	-3.4	-4.7	-4.5

(Continued)

TABLE 5. (Continued)

Hospital Category	Number of Hospitals	PPS and Capital Payments Under Previous Law (1991, in millions of dollars) a/	Change in PPS and Capital Payments Under OBRA-90 (In percent) 1991	1995	1991-95
Major Teaching					
Disproportionate share	176	6,520	-3.2	-3.5	-3.8
Nondisproportionate share	52	2,270	-3.5	-5.0	-4.5
Other Teaching					
Disproportionate share	421	9,730	-3.4	-4.3	-4.3
Nondisproportionate share	542	12,250	-3.4	-5.0	-4.6
Urban					
≤ 100 beds	846	2,690	-3.9	-5.1	-4.8
101-200 beds	870	8,370	-3.9	-4.7	-4.6
201-400 beds	1,002	22,270	-3.6	-4.7	-4.5
401+ beds	391	17,890	-3.4	-4.5	-4.4
Rural					
≤ 50 beds	1,390	1,530	-2.3	-1.6	-1.8
51-100 beds	744	2,390	-2.6	-1.9	-2.0
101-200 beds	379	2,830	-3.1	-3.3	-3.2
201+ beds	115	1,820	-3.3	-4.4	-4.2
New England	244	3,610	-3.6	-4.7	-4.2
Middle Atlantic	637	11,650	-3.7	-4.3	-4.4
South Atlantic	781	9,190	-4.1	-4.4	-4.4
East North Central	868	10,350	-2.6	-4.6	-4.0
East South Central	493	3,930	-3.7	-4.2	-4.2
West North Central	799	4,290	-2.9	-4.3	-4.1
West South Central	824	5,750	-3.5	-4.3	-4.3
Mountain	398	2,530	-3.4	-4.3	-4.2
Pacific	693	8,470	-3.6	-4.3	-4.3
Voluntary	3,235	44,140	-3.4	-4.5	-4.3
Proprietary	1,161	7,540	-4.2	-4.5	-4.5
Urban Government	447	5,880	-3.2	-3.8	-3.9
Rural Government	894	2,200	-2.7	-2.5	-2.6

SOURCE: Congressional Budget Office estimates based on data provided by the Health Care Financing Administration and other sources.

TABLE 5. (Continued)

NOTES: The estimates in the table are incurred amounts for fiscal years under CBO's summer 1990 baseline. OBRA-90 refers to the Omnibus Budget Reconciliation Act of 1990. Previous law means the law in effect on September 30, 1990.

The amounts in the table do not reflect any potential effects that the transition to prospectively determined payments for capital-related expenses might have on the distribution of payments among hospital categories in 1995 or for the 1991-1995 period.

Details may not sum to totals because of rounding.

a. Payments are equal to prospective payment system (PPS) payments--i.e., those payments based on diagnosis-related groups and adjusted for "disproportionate share," the indirect costs related to teaching, and other factors--plus payments to hospitals covered by the PPS for capital-related expenses. Payments for the direct costs of graduate medical education, and other "pass-throughs" are not included.

b. MSA > 1 million indicates hospitals located in Metropolitan Statistical Areas with populations of more than 1 million.

c. Sole community hospitals that are also rural referral hospitals are included in the rural referral category.

d. A Medicare dependent hospital is a rural hospital with 100 or fewer beds that is not a sole community hospital, and in which at least 60 percent of inpatient discharges or days during the hospital's 1987 fiscal year were attributable to Medicare beneficiaries. Medicare dependent hospitals qualify for payments similar to those for sole community hospitals (through March 1993).

e. Major teaching hospitals are those hospitals for which the ratio of the number of full-time equivalent interns and residents to the number of beds is .25 or larger.

Provisions Affecting Payments to Physicians

The changes described below were effective as of January 1, 1991. The act also reduced reimbursement amounts (by 2 percent) to all SMI providers for services provided during November and December of 1990. Further, as of 1992, it will prohibit separate payment for interpretation of an electrocardiogram (EKG) if the EKG is ordered or performed as part of a visit for which reimbursement is claimed. In addition, the act specifies that the update to payment rates that would otherwise occur for 1992 is to be reduced by 0.4 percentage points.

Limiting of Payment Rates for New Physicians. Under previous law, new physicians not practicing in areas where a health manpower shortage exists had their customary charges for services other than primary care set at 80 percent of the applicable prevailing charge in their first year of practice, and at 85 percent in their second year. (In other cases, the customary charge for a new physician is set at the median of customary charges for other physicians in the locality. This amount may exceed the prevailing charge.) In subsequent years, customary charges for new physicians were calculated in the usual way, using each physician's own history of charges. Under OBRA-90, the customary charge will be limited to 90 percent of the prevailing charge during a new physician's third year, and to 95 percent during the fourth year. In 1992, when the Medicare fee schedule is implemented, fees for new physicians will be discounted as indicated above for the first four years of practice.

Reduction in Payments for Clinical Laboratory Services. Clinical laboratory services are paid under a fee schedule specific to each locality, subject to a ceiling previously set at 93 percent of the national median fee for each service. Under OBRA-90, fees for 1991 will be increased by 2 percent (instead of the full increase in the Consumer Price Index). Further, the ceiling will be reduced to 88 percent of the national median fee for each service.

Reduction in Prevailing Charges for Certain Overvalued Procedures. Prevailing charges for services identified as overvalued in last year's budget reconciliation act will be reduced again for 1991, by the same dollar amount as they were reduced for 1990 under the Omnibus Budget Reconciliation Act of 1989 (OBRA-89). This will affect 36 groups of procedures (such as the group for lens extractions) containing 245 specific procedure codes. For 1990, these procedures were reduced by the lesser of 15 percent or one-third of the difference between the 1989 prevailing charge and an estimate of what the payment rate would have been under the Medicare Fee Schedule. Because payment rates for these services are now lower than they were last year, a reduction by the same dollar amount will be a larger percentage cut. (A 15 percent reduction in 1990 would mean a reduction of 17.6 percent for 1991, for instance.)

Reduction in Fees for Radiology Services. Radiology services are currently paid under a fee schedule implemented in 1989. For each radiology service, the 1991 fee will be 87 percent of a blended rate, subject to both a floor and a ceiling. One-half of the blended rate will be the locality-specific fee in 1990. The other half will be the average fee nationwide in 1990, adjusted for differences across localities in

practice costs. The floor will be set at the larger of 60 percent of the 1990 national average fee for each service, or 90.5 percent of the 1990 locality-specific fee. The ceiling will be set at the 1990 locality-specific fee for each service. Fees for the technical components of certain services (magnetic resonance imaging and CAT scans) will be cut by an additional 10 percent. Specialists in nuclear medicine will continue to have their fees set by a different procedure, at a rate blended from their historic prevailing charges and the radiology fee schedule.

Reduction in Prevailing Charges for Anesthesiology Services. Prevailing charges for anesthesiology services will be reduced in most localities. The national average rate for 1990 will be reduced by 7 percent, adjusted by an index of practice costs, and then used as a target rate in each locality. If the 1990 prevailing charge in the locality was higher than the target rate, it will be reduced to the target so long as the reduction does not exceed 15 percent. If the 1990 charge was below the target rate and at least 60 percent of the 1990 national average, it will be unchanged. If the 1990 charge was less than a floor set at 60 percent of the national average, it will be increased to the floor.

Reduction in Prevailing Charges for Pathology Services. Prevailing charges for pathology services will be reduced by 7 percent from their 1990 levels in each locality.

Limiting of Prevailing Charges for the Technical Component of Certain Diagnostic Tests. The prevailing charge for the technical component of specified diagnostic tests will be limited to no more than the national median charge for such services. The Secretary of the Department of Health and Human Services is to designate the procedures to be affected by this provision, based on the number of tests performed in the most recent year for which data are available.

Reduction of Prevailing Charges for "Unsurveyed" Procedures. Prevailing charges for services that will not be affected by any of the reductions already described, and that are not defined as "evaluation and management" services, will be reduced by 6.5 percent for 1991. Evaluation and management services include all services defined as primary care (mainly office visits), as well as hospital visits and consultations. An additional 25 services specified in the act are exempted from this reduction because they are not thought to be overvalued.

Reduction in the Update to Prevailing Charges for Services Not Already Affected by Reductions. Prevailing charges for primary care services (specified visit codes) will be increased by 2 percent for 1991, less than the full cost-based update that would otherwise have taken place. Customary charges for primary care services will be updated in the usual manner. For any other services not affected by provisions already described, both prevailing and customary charges will be frozen at their 1990 levels. This change will affect services that are defined as evaluation and management, but not primary care, and includes hospital visits and consultations. It will also affect the 25 services specifically exempted from the 6.5 percent reduction described just above.

Increase in the Floor on Rates for Primary Care Services. Prevailing charges for primary care services may not be less than 60 percent of the national average prevailing charge for the service in 1991. In 1990, the floor was set at 50 percent of the national average prevailing charge.

Limiting of Patient Liability for Evaluation and Management Services. OBRA-89 specified that, in 1991, the actual charge for services provided by nonparticipating physicians could not exceed 125 percent of the physician's prevailing charge for that service. OBRA-90, however, grants an exception for evaluation and management services for 1991 only, allowing actual charges up to 140 percent of the physician's prevailing charge.

Reduction in Prevailing Charges for Assistants at Surgery. Prevailing charges for physicians acting as assistants at surgery will be reduced from 20 percent to 16 percent of the prevailing charge for the primary surgeon. In addition, no payment for an assistant will be approved for procedures where assistants have previously been used in fewer than 5 percent of the cases.

Estimated Effects on Physicians

With one exception, all of the payment provisions effective for 1991 described above are included in the simulation results reported here. Data limitations prevent the inclusion of the provisions that will alter payment rates for new physicians. The simulations use 1987 claims data, adjusted to reflect 1991. They show the estimated effects for a full year, both overall and separately for urban and rural areas, by specialty.

Results are presented in terms of the percentage reduction in rates or in payments for Medicare-covered services that physicians will experience for 1991, relative to what would have occurred under previous law. The percentage changes that will result in subsequent years will be somewhat larger because of the two additional reductions (described earlier) that will be effective for 1992.

Changes in rates indicate as well the initial impact on physicians' payments or receipts for Medicare services, before any behavioral responses. For its estimates, however, CBO assumes that behavioral responses to rate changes by physicians or their patients will alter the number or mix of services provided. As a result, the ultimate change in Medicare's payments or physicians' receipts for Medicare-covered services will differ from the initial impact. In particular, CBO currently assumes that about half of the initial impact of a rate reduction will be offset by an increase in the volume of services provided. No volume offset is assumed for rate increases.

Effects On Payment Rates and Effective Rates. On average over all specialty groups and areas, Medicare's payment rates for 1991 will be 8 percent lower than they would have been under previous law (Table 6). The reduction in effective rates (payment rates on assigned claims, and actual charges on unassigned claims) will be

only slightly smaller, reflecting the small proportion of claims that are unassigned and unconstrained by Medicare's limits on actual charges.[11]

Medical specialties will face payment rate reductions of 5.6 percent, on average, while payment rates for surgical specialties will be 10.1 percent lower, on average. Both radiologists and anesthesiologists will face rate reductions of more than 10 percent, while reductions for pathologists will be about 9 percent.

Rate reductions in rural areas will be somewhat smaller than reductions in urban areas. Over all specialties, payment rates will be 8.1 percent lower in urban areas, and 7.8 percent lower in rural areas.

Effects On Medicare's Payments and Physicians' Receipts.[12] As a result of behavioral responses by physicians or their patients, the potential effects of the rate changes made under OBRA-90 are expected to be cut about in half. While payment rates will be reduced by 8 percent overall under the act, total payments for Medicare-covered services to physicians will be reduced only by 4.1 percent (Table 7). The reduction in physicians' receipts (Medicare's payments on assigned claims, and payments plus balance-billing amounts on unassigned claims) for Medicare services will be only slightly less, again reflecting the small proportion of claims that are unassigned and unconstrained by Medicare's limits on actual charges.

Except that the changes are only half as large, the effects on Medicare's payments and physicians' receipts follow the same pattern as the effects on rates. Surgical specialties will experience larger reductions (about 5 percent) than will medical specialties, whose reductions will be under 3 percent. On average, reductions in urban areas will be slightly more than 4 percent, while those in rural areas will be just under 4 percent.

---

11. For most services in 1991, actual charges may not exceed 125 percent of the prevailing charge.

12. Medicare's payments include reimbursement amounts paid by the federal government plus enrollees' copayments.

TABLE 6. THE CHANGE IN PAYMENT RATES AND EFFECTIVE RATES FOR PHYSICIANS' SERVICES UNDER OBRA-90 RELATIVE TO PREVIOUS LAW (In percent)

		Percentage Change for 1991					
		All Areas		Urban Areas		Rural Areas	
	Initial Share of Payments	Payment Rates	Effective Rates	Payment Rates	Effective Rates	Payment Rates	Effective Rates
All Specialties	100	-8.0	-7.9	-8.1	-8.0	-7.8	-7.6
Medical Specialties	43	-5.6	-5.4	-5.7	-5.5	-5.1	-4.9
General practice	4	-4.0	-3.9	-4.2	-4.0	-3.4	-3.3
Family practice	5	-4.0	-3.9	-4.2	-4.0	-3.7	-3.6
Internal medicine	18	-5.0	-4.8	-5.0	-4.8	-5.0	-4.8
Other	16	-7.2	-7.0	-7.1	-7.0	-7.5	-7.3
Surgical Specialties	34	-10.1	-10.0	-10.1	-10.1	-9.9	-9.8
General practice	7	-10.3	-10.3	-10.6	-10.5	-9.0	-8.9
Ophthalmology	11	-10.1	-10.0	-10.0	-9.9	-10.5	-10.5
Orthopedic surgery	5	-9.5	-9.5	-9.5	-9.4	-9.8	-9.7
Thoracic surgery	3	-14.5	-14.4	-14.5	-14.4	-14.5	-14.3
Urology	4	-8.6	-8.5	-8.7	-8.6	-8.4	-8.3
Other	4	-8.5	-8.4	-8.4	-8.4	-9.2	-9.2
Other Specialties	22	-9.5	-9.4	-9.5	-9.4	-9.4	-9.3
Pathology	1	-9.1	-9.0	-9.1	-9.0	-9.2	-9.0
Clinics	7	-7.8	-7.7	-7.7	-7.6	-8.6	-8.4
LLPs	2	-7.8	-7.7	-7.8	-7.7	-7.3	-7.2
Anesthesiology	4	-10.2	-10.2	-10.4	-10.4	-8.5	-8.4
Radiology	9	-10.9	-10.8	-10.9	-10.8	-10.6	-10.5

SOURCE: Congressional Budget Office simulations from 1987 Part B Medicare Annual Data beneficiary file, modified to represent 1991.

NOTES: The effective rate is Medicare's payment rate for assigned claims, and the physician's actual charge on unassigned claims. The estimates in the table are incurred amounts for calendar year 1991 under CBO's summer 1990 baseline. OBRA-90 refers to the Omnibus Budget Reconciliation Act of 1990. Previous law means the law that was in effect on December 30, 1990.

TABLE 7. THE CHANGE IN MEDICARE'S PAYMENTS AND PHYSICIANS' RECEIPTS UNDER OBRA-90 RELATIVE TO PREVIOUS LAW, AFTER INCORPORATING BEHAVIORAL RESPONSES (In percent)

		Percentage Change for 1991					
		All Areas		Urban Areas		Rural Areas	
	Initial Share of Payments	Medicare Payments	Physician Receipts	Medicare Payments	Physician Receipts	Medicare Payments	Physician Receipts
All Specialties	100	-4.1	-4.0	-4.1	-4.0	-3.9	-3.8
Medical Specialties	43	-2.9	-2.7	-2.9	-2.8	-2.6	-2.4
General practice	4	-2.1	-1.9	-2.1	-2.0	-1.7	-1.6
Family practice	5	-2.1	-1.9	-2.2	-2.0	-1.9	-1.8
Internal medicine	18	-2.6	-2.4	-2.6	-2.4	-2.6	-2.4
Other	16	-3.7	-3.5	-3.6	-3.5	-3.9	-3.6
Surgical Specialties	34	-5.1	-5.0	-5.1	-5.0	-5.0	-4.9
General practice	7	-5.2	-5.1	-5.3	-5.3	-4.5	-4.4
Ophthalmology	11	-5.1	-5.0	-5.0	-5.0	-5.3	-5.2
Orthopedic surgery	5	-4.8	-4.7	-4.8	-4.7	-4.9	-4.9
Thoracic surgery	3	-7.3	-7.2	-7.2	-7.2	-7.3	-7.2
Urology	4	-4.4	-4.3	-4.4	-4.3	-4.2	-4.2
Other	4	-4.3	-4.2	-4.3	-4.2	-4.6	-4.6
Other Specialties	22	-4.8	-4.7	-4.8	-4.7	-4.8	-4.7
Pathology	1	-4.6	-4.5	-4.6	-4.5	-4.6	-4.5
Clinics	7	-4.0	-3.9	-3.9	-3.8	-4.3	-4.2
LLPs	2	-3.9	-3.8	-3.9	-3.8	-3.8	-3.6
Anesthesiology	4	-5.1	-5.1	-5.2	-5.2	-4.3	-4.2
Radiology	9	-5.5	-5.4	-5.5	-5.4	-5.4	-5.2

SOURCE: Congressional Budget Office simulations from 1987 Part B Medicare Annual Data beneficiary file, modified to represent 1991.

NOTES: Physicians' receipts are Medicare's allowed amounts on assigned claims, but they are allowed amounts plus balance-billing amounts on unassigned claims. The estimates in the table are incurred amounts for calendar year 1991 under CBO's summer 1990 baseline. OBRA-90 refers to the Omnibus Budget Reconciliation Act of 1990. Previous law means the law that was in effect on December 30, 1990.

APPENDIX A

APPENDIX TABLE 1. COST ESTIMATES FOR MEDICARE PROVISIONS UNDER OBRA-90 (In fiscal years, millions of dollars)

		1991	1992	1993	1994	1995	Total
	Provisions Relating Only to Part A						
4001	Payments for capital-related costs of inpatient hospital services d/	-810	-720	-760	-840	-920	-4,050
4002	Prospective payment hospitals a/,d/	-385	-1,335	-2,240	-2,445	-2,485	-8,890
4003	Expansion of DRG payment window	-45	-110	-120	-135	-145	-555
4004	Payments for medical education costs	205	220	115	-15	-45	480
4005	PPS-exempt hospitals	0	20	35	40	45	140
4006	Hospice benefit extension	*	*	1	1	1	4
4007	Freeze in payments under part A through December 31 d/	-495	0	0	0	0	-495
4008	Miscellaneous and technical provisions relating to part A	35	45	50	55	60	245
	Subtotal Part A	-1,495	-1,880	-2,919	-3,339	-3,489	-13,122
	Provisions Relating Only to Part B						
4101	Certain overvalued procedures e/	-370	-605	-670	-745	-825	-3,215
4102	Radiology services b/,e/	-135	-230	-255	-290	-330	-1,240
4103	Anesthesia services b/,e/	-25	-40	-45	-50	-60	-220
4104	Physician pathology services e/	-5	-10	-15	-15	-15	-60
4105	Update for physicians' services e/	-305	-570	-655	-725	-805	-3,060
4106	New physicians and other new health care practitioners	-55	-105	-125	-140	-155	-580
4107	Assistants at surgery e/	-30	-50	-55	-60	-65	-260
4108	Technical components of certain diagnostic tests b/,e/	-20	-40	-40	-50	-50	-200
4109	Interpretation of electrocardiograms	0	-110	-185	-205	-225	-725

(Continued)

APPENDIX TABLE 1. (Continued)

		1991	1992	1993	1994	1995	Total
4110	Reciprocal billing arrangements	0	0	0	0	0	0
4111	Study of prepayment medical review screens	0	0	0	0	0	0
4112	Practicing physicians advisory council	0	0	0	0	0	0
4113	Study of aggregation rule for claims for similar physicians' services	0	0	0	0	0	0
4114	Utilization screens for physician visits in rehabilitation hospitals	0	0	0	0	0	0
4115	Study of regional variations in impact of medicare physician payment reform	0	0	0	0	0	0
4116	Limitation on beneficiary liability e/	0	0	0	0	0	0
4117	Statewide fee schedule areas for physicians' services	0	0	0	0	0	0
4118	Technical corrections	0	0	0	0	0	0
4151	Payments for hospital outpatient services	-355	-450	-520	-605	-710	-2,640
4152	Durable medical equipment b/	-205	-375	-460	-520	-580	-2,140
4153	Provisions relating to orthotics and prosthetics	-35	-60	-65	-70	-75	-305
4154	Clinical diagnostic laboratory tests e/	-90	-185	-270	-325	-365	-1,235
4155	Coverage of nurse practitioners in rural areas	3	4	4	5	5	21
4156	Coverage of injectable drugs for treatment of osteoporosis	8	15	15	15	20	73
4157	Separate payment under part B for services of certain health practitioners	*	*	1	1	1	3
4158	Reduction in Part B payments under part B during final 2 months of 1990	-95	0	0	0	0	-95

(Continued)

APPENDIX TABLE 1. (Continued)

		1991	1992	1993	1994	1995	Total
4159	Payments for medical education costs	25	30	15	0	-5	65
4160	Certified registered nurse anesthetists	45	70	80	90	110	395
4161	Community health centers and rural health clinics	0	35	40	45	50	170
4162	Partial hospitalization in community mental health centers	0	10	15	15	20	60
4163	Coverage of screening mammography a/	140	235	265	290	320	1,250
4164	Miscellaneous and technical provisions relating to part B	0	0	0	0	0	0
	Subtotal Part B	-1,504	-2,431	-2,925	-3,339	-3,739	-13,938
	Provisions Relating to Parts A and B						
4201	Provisions relating to end stage renal disease	-5	0	5	10	15	25
4202	Staff-assisted home dialysis demonstration project	4	4	3	2	1	14
4203	Extension of secondary payer provisions c/	-50	-825	-1,370	-1,780	-2,060	-6,085
4204	Health maintenance organizations						
4205	Peer review organizations	0	0	0	0	0	0
4206	Medicare provider agreements assuring a patient's right to participate in and direct health care decisions affecting the patient	0	0	0	0	0	0
4207	Miscellaneous and technical provisons relating to parts A and B						
	(Direct Spending)	15	20	25	30	30	120
	(Subject to Appropriation)	4	2	1	0	0	7
	Subtotal Parts A and B						
	(Direct Spending)	-36	-801	-1,337	-1,738	-2,014	-5,926
	(Subject to Appropriation)	4	2	1	0	0	7

(Continued)

APPENDIX TABLE 1. (Continued)

		1991	1992	1993	1994	1995	Total
	Provisions Relating to Part B Premium and Deductible						
4301	Part B Premium c/						
	Medicare Savings	0	-180	-1,270	-2,580	-4,050	-8,080
	Medicaid Offset	0	15	100	200	310	625
	Net Savings	0	-165	-1,170	-2,380	-3,740	-7,455
4302	Part B Deductible						
	Medicare Savings	-380	-595	-610	-620	-635	-2,840
	Medicaid Offset	30	50	50	50	50	230
	Net Savings	-350	-545	-560	-570	-585	-2,610
	Subtotal Part B Premium	-350	-710	-1,730	-2,950	-4,325	-10,065
	Medicare Supplemental Insurance Policies						
4359	Health insurance advisory services for Medicare beneficiaries (Subject to Appropriation)	4	5	5	5	5	24
4360	Health insurance information, counseling, and assistance grants (Subject to Appropriation)	9	10	10	2	0	31
4361	Medicare and medigap information by telephone (Subject to Appropriation)	9	10	10	10	10	49
	Subtotal Medicare Supplemental Policies	22	25	25	17	15	104
	Summary						
	Direct Spending						
	Part A	-1,495	-1,880	-2,919	-3,339	-3,489	-13,122
	Part B	-1,504	-2,431	-2,925	-3,339	-3,739	-13,938
	Parts A and B	-36	-801	-1,337	-1,738	-2,014	-5,926
	Part B Premium and Deductible	-350	-710	-1,730	-2,950	-4,325	-10,065
	Subtotal Direct Spending	-3,385	-5,822	-8,911	-11,366	-13,567	-43,051
	Amount Subject to Appropriations Action:						
	Parts A and B	4	2	1	0	0	7
	Medicare Supplemental Policies	22	25	25	17	15	104
	Subtotal Subject to Appropriations	26	27	26	17	15	111

(Continued)

APPENDIX TABLE 1. (Footnotes)

SOURCE: Congressional Budget Office.

NOTES: The estimates in these tables are outlays for fiscal years under CBO's summer 1990 baseline. OBRA-90 refers to the Omnibus Budget Reconciliation Act of 1990.

* Means the estimate is less than 0.5 million.

a. The conferees agreed to offset the costs of the screening mammography (Section 4163) and regional floor (Section 4002 (e)) provisions through deficit reduction measures under the jurisdiction of the House Ways and Means and Senate Finance Committees other than reductions in spending under the Medicare program. The five-year cost of the regional floor provision is $365 million.

b. Estimates of these provisions reflect the intent of Congress and HCFA's implementation.

c. Premium receipts and increases in collections from primary insurers are presented as negative outlays.

d. The effects of these provisions are included in the simulation results discussed in the section on the impact of OBRA-90 on PPS hospitals.

e. The effects of these provisions are included in the simulation results discussed in the section on the impact of OBRA-90 on physicians.